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# Mindfulness Groups for Psychosis; Key Issues for Implementation on an Inpatient Unit

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**Background:** There is emerging evidence that mindfulness groups for people with distressing psychosis are safe and therapeutic. **Aims:** The present study aimed to investigate the feasibility of running and evaluating a mindfulness group on an inpatient ward for individuals with chronic and treatment resistant psychosis. **Method:** Eight participants attended a 6-week mindfulness group on a specialist tertiary inpatient ward. **Results:** This study demonstrated that mindfulness exercises were acceptable and well-tolerated by participants. Measuring outcome, systemic challenges and participant experience are discussed.

*Keywords:* Mindfulness, psychosis, psychological therapies, group psychotherapy.

## Applications of mindfulness in psychosis

Mindfulness-based interventions have become increasingly popular over the past few years in treating both physical and mental health problems. Mindfulness-based approaches are still an emerging area in general, and particularly in psychosis. Individuals who are distressed by their psychotic symptoms often engage in experiential avoidance strategies (e.g. distraction, suppression, substance misuse) or go to the other extreme, and get lost in the struggle of rumination and confrontation of symptoms. Mindfulness provides participants with an alternative way of relating to their psychotic symptoms such as voices, images, or intrusive thoughts, which may lead to a reduction in associated distress. It has now been shown that with the appropriate modifications, mindfulness groups for people with distressing psychosis are safe and lead to improvements on measures of general clinical functioning (e.g. Chadwick, Newman-Taylor and Abba, 2005; Chadwick, Hughes, Russell, Russell and Dagnan, 2009).

In addition to examining the efficacy of mindfulness groups in psychosis, recent research in this population has also addressed the topic of participants' experience of mindfulness. A grounded theory analysis of 16 individuals with psychosis who had taken part in an outpatient

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mindfulness group (Abba, Chadwick and Stevenson, 2008) suggested that mindfulness helps people to relate differently to the psychotic experience, specifically by opening awareness to the experience, allowing the experience to be as it is (allowing thoughts and voices to come and go without reacting), and reclaiming power through accepting oneself and the experience. Consistent with this, York (2007) reported qualitative outcomes for a mindfulness group run on an acute inpatient unit, which included some participants with psychosis. They reported a range of subjective benefits, such as the ability to accept and tolerate difficult thoughts and feelings, and a sense of greater calm and peace of mind.

In summary, mindfulness groups for people with psychosis have an emerging evidence base and appear to be experienced by participants as therapeutic. Research thus far has focused on a small number of outpatients with psychosis, as well as a few patients on a secondary care acute inpatient ward. It is not yet known whether mindfulness groups can be successfully applied within a specialist tertiary inpatient setting. The present paper discusses the feasibility and challenges of running and evaluating a mindfulness group on an inpatient ward for individuals with complex and treatment-resistant psychosis.

## Method

### *Setting up the group: participants and protocol*

Approval for this service evaluation project was given by the Local Clinical Governance Committee. Participants were inpatients on the National Psychosis Unit (NPU) at the Bethlem Royal Hospital, which specializes in the assessment and treatment of people with complex psychosis. Anyone with distressing symptoms was invited to join the group, as long as their attendance would not significantly disrupt or disturb other participants (18 out of a total of 20 patients). Eight participants (5 female, 3 male) attended at least 1 session. They had an average age of 30 years (range 21–43), with an average length of contact with services of 12 years (range 5–24). They were all unemployed, single and were taking anti-psychotic medication.

The group ran weekly for 1 hour for 6 weeks. The group format was the same each week, providing a consistent and familiar structure for participants, and allowing greater accommodation for sporadic attendance. Each session included facilitated group discussion and two 10-minute breathing meditations, following the protocol used by Chadwick et al. (2005). Each participant was given a copy of a mindfulness CD, which they were invited (but not required) to practise with during the week. Group attendance ranged from 3–5 participants each week, with a mean of 3.8 participants per session. Individual participants attended a mean number of 2.9 sessions each, with a range of 1–6 sessions.

### *Assessment issues*

*Pre-Post standardized outcome measures.* There are many challenges to collecting outcome data in an inpatient setting in everyday clinical practice. Standardized questionnaires are often difficult for patients to complete due to a number of factors, including cognitive difficulties, symptom interference and reluctance to disclose difficulties. Participants who took part in our group were invited to complete outcome measures at 6 weeks baseline, session 1 and session 6 of the group (*Psychotic Symptoms Rating Scales* – PSYRATS; Haddock, McCarron, Tarrier and Faragher, 1999; *Southampton Mindfulness Questionnaire* – SMQ;

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Chadwick et al., 2008). A key finding was that it was difficult to collect baseline data because participants were uncertain about committing to the group at that point. In addition, there was incomplete symptom data (PSYRATS) because this measure had not been completed for all participants as part of routine practice.

*Within session outcome measures*

A key question relating to the application of mindfulness in psychosis is whether it is possible to detect an immediate beneficial effect of participating in a session. This is particularly pertinent for participants who may attend only 1 or 2 sessions, and for whom pre-post measures may not be informative, or difficult to interpret due to the level of generic intervention on an inpatient unit. However, it is important to note that scores may increase immediately following mindfulness, as individuals become aware of experiences that they may have been previously avoiding or suppressing. In order to investigate this issue, and taking into account the difficulties with completing standardized measures as discussed above, participants also completed a measure of stress and symptom interference before and after every group session (*stress bubbles*[1]). This was a form of visual analogue scale, with 6 bubbles gradually increasing in size from "no stress" (1) to "very stressed" (6). A parallel version was also used to assess symptom interference, with bubbles ranging from "no interference" to "very interfering". Six out of 8 participants completed stress bubbles before and after every session they attended. One participant left session 1 early and so only completed the pre-session measure and another participant found the measure too difficult to understand and so did not complete it. Available data for the 6 participants who completed stress bubbles are shown in Figure 1.

## Results

The small-data set precludes formal statistical analysis; however, in general, Figure 1 indicates that there were small shifts in stress and interference ratings from pre-post session, although the direction of difference varied across sessions, and as such the current data are inconclusive. As group averages may mask variations in individual responses over time, it may be helpful to also calculate change scores (post-pre) across sessions when analyzing larger data sets.

*Participants' experience of the group*

Chadwick's protocol of short breathing meditations was accessible and acceptable to participants. Breathing meditations across all the sessions were completed for the full 10 minutes each time, and never had to be terminated early. In general, participants were able to sit still and quietly for each 10 minute meditation, although 2 participants used additional coping stragies such as whispering back to voices or doodling on paper if needed. We found that the approach of inviting, rather than requiring, participation in exercises during the session and practice between sessions appeared to work well for participants. Participants were also able to reflect on their experiences of mindfulness within the session;

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[1] We are thankful to Tamara Russell for permission to adapt this unpublished measure for this study.

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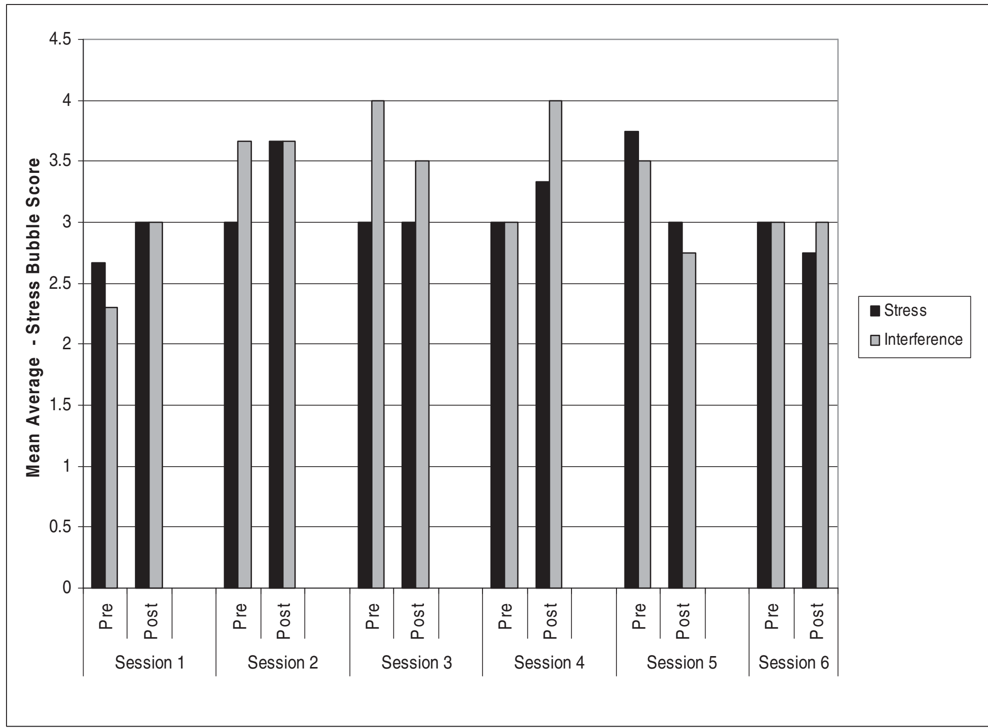


**Figure 1.** Mean scores on the stress bubbles, pre- and post each session

for example, relating them to previous meditative experiences such as being in a church or out in nature. This is significant, as practice and reflective learning are considered to be of equal importance in mindfulness for psychosis (Chadwick et al., 2005). It is of note that participants also demonstrated a mindful (non-judgemental and accepting) attitude to other participants' descriptions of their mental experiences.

Seven out of 8 participants agreed to complete a feedback questionnaire after the group had finished. Participants identified positive aspects of the group, such as "very soothing for the soul", "atmosphere was comfortable" and "I found it relaxing therapeutically". Participants were also able to identify things that made it more difficult to benefit from the group, including distractions from noise outside ("the noise playing and people passing by"), and the group running for a limited number of weeks ("it didn't go long enough").

*Systemic challenges*

There are always challenges in establishing group interventions in an inpatient setting, particularly for relatively novel approaches with which ward staff may be unfamiliar. For this reason, a key part of the preparation for running the group involved staff education and multi-disciplinary team liaison to promote awareness and understanding of the principles of mindfulness. Staff support was also vital in enabling participants to attend the group

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each week, given the inevitable disruptions of ward life. A remaining challenge is how to integrate mindfulness into the ward milieu, given that mindfulness promotes non-judgemental awareness and tolerance of difficult experiences, whereas ward interventions such as administering PRN medication for distress are aimed at experiential control and symptom reduction.

## Summary and implications

We have found that it is possible to run a mindfulness group in a specialist inpatient setting where participants are experiencing chronic, distressing and treatment-resistant psychosis. In particular, this suggests that this clinical population can (i) tolerate short sitting meditations, (ii) reflect on these experiences, and (iii) relate these to experiences in their everyday lives. This a key finding that links back to the original application of mindfulness in improving outcomes for clinical populations who have not responded to conventional treatment (e.g. chronic pain). Larger data-sets are required in order to demonstrate any clinically significant change arising from inpatient mindfulness groups. Future research should also further investigate the most effective format for its delivery (e.g. number of weeks, open vs. closed groups, running mixed staff/participant groups) using standardized measures, as well as mechanisms of change and connections to cognitive theory.

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